

ATTACHMENT 7

Sample Prior Authorization Request Form (PA/RF) for personal care services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number 1234567
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SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code) I.M. Provider 10 W. Williams Anytown, WI 55555	2. Telephone Number — Billing Provider (555) 123-4567	3. Processing Type 121
	4. Billing Provider's Medicaid Provider Number 87654321	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.	9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description 401.9 — hypertension NOS		11. Start Date — SOI	12. First Date of Treatment — SOI						
13. Diagnosis — Secondary Code and Description 250.0 — diabetes II (NIDDM)		14. Requested Start Date							
15. Performing Provider Number	16. Procedure Code	17. Modifiers 1 2 3 4				18. POS	19. Description of Service	20. QR	21. Charge
	T1019					12	Personal care services 56 units/wk x 53 wks	2,968	XXX.XX
	T1019	U3				12	Personal care travel time 4 units/wk x 53 wks	212	XXX.XX
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.								22. Total Charges	x,xxx.xx

23. SIGNATURE — Requesting Provider

I.M. Requesting

24. Date Signed
MM/DD/YY

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

☐ Approved

Grant Date

Expiration Date

☐ Modified — Reason:

☐ Denied — Reason:

☐ Returned — Reason:

SIGNATURE — Consultant / Analyst

Date Signed